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CENTRAL INTELLIGENCE AGENCY

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Remarks:

Keep this for future reference as a possible increase in our hospitalization program.

STAT

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FORM NO. 237 Use previous editions
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2 MAY 1968

MEMORANDUM FOR FILE

Group Policy GMG-1799
Government Employees Health Assn.

At the request of the policyholder, we have investigated the possibility of providing additional benefits for mentally retarded children and emotionally disturbed children. We found this a very new area of much current study, and as in any such new field, containing a good deal of change and evolution.

In regard to mentally retarded children, it is common practice to divide them into three categories according to I.Q. It is recognized that using this criteria leads to rather fuzzy breaking points, but no better measurement has been developed to date.

1) Custodial - with I.Q. ranging from 0 to the low 20's. These children are usually placed in institutions for life.

2) Trainable - with I.Q. ranging from low 20's to mid 60's. These children can be trained to live self-supporting lives. They will lead sheltered lives, and will not be capable of accepting responsibilities of a family.

3) Educable - with an I.Q. of from mid 60's to mid 80's. These children can become clerks, elevator operators, et cetera. They usually have a normal drive for success but lack the ability to control the drive.

Many public and private schools have been established in the recent past to train and educate these children. They usually specialize in one of the last two categories. The public schools seem to be more active in the area of the educable child, with private schools being established for the trainable. Both types of schools normally require that a child be tested by a recognized psychologist, such as those at Nebraska Psychiatric Institute, and undergo a very thorough physical exam prior to acceptance. Most of these children are discovered when they attain school age and tests will usually not be given until then.

Emotionally disturbed children can be separated from the retarded children through the above tests and are not usually accepted by the schools for retarded children. There are day care centers for these children, and current thinking is that they should be left in their own environment (family, neighborhood, church, et cetera) whenever possible. Emotional disturbance usually results from an exterior cause, such as a physical handicap or family friction, and it is possible to alleviate or remove the cause, bringing much improvement.

The variety of work that is currently being done in these fields has unfortunately led to a variety of definitions, and, hence, statistics are often not of the desired reliability.

As indicated above, we have investigated the possibility of providing some sort of benefit for mental retardation in general. Even though this is highly experimental, we believe it to be feasible and propose the following approach for consideration.

1. Mental retardation exists in many forms and degrees of severity within those forms. Many conditions are as yet unidentifiable as to cause. In most cases, no specific medical treatment is available.

2. For insurance purposes, merely defining mental retardation can pose severe problems. Our intention was to provide help for the severely retarded and not concern ourselves with those classified as "educable" as this segment is absorbed into the general population as adults.

3. Investigation determined that the severely retarded segments are either identifiable at birth or as preschoolers, with the "educables" being identified during the early grade school years.

4. Our proposal is based upon this method of definition - we will provide benefits for any mental retardation diagnosed prior to attainment of the sixth birthday.

5. We would propose an indemnity benefit of $50 per month for a maximum of 50 months during the lifetime of the dependent. This would, in effect, provide an "adjustment period" during which those parents whose child would require nonpublic training or maintenance could move to adjust their financial patterns. In addition, it would provide a ready facility for payment in regard to the Claim Department and would not create a great burden on a new experimental coverage. Once the diagnosis was established, payment would be automatic as long as the child was alive and as long as the parents were incurring expense up to a maximum of 50 weeks.

6. Our Actuarial Department has calculated that we would provide this experimental benefit at a premium rate of 25¢ per family unit per month.

AWR:MH

A. W. Randall

May 2, 1967